per-diem rate. No payments may be collected or retained in addition to the Medicaid per-diem rate for covered services. Where third-party payment is involved, Medicaid will be the payer of last resort with the exception of state programs such as Vocational Rehabilitation and the Missouri Crippled Children's Services. A provider participating under this rule shall not be eligible for participation under any other Missouri Medicaid plan for the provision of nursing care services.

(E) The Medicaid per-diem rate shall be the lower of:

1. The average private pay rate;

2. The Medicare (Title XVIII) per-diem rate, if applicable;

3. The per-diem rate as determined in accordance with section (11); or

4. The level-of-care ceiling. The level-of-care ceiling in effect on and after December 1, 1992, shall be the weighted average Medicaid allowable cost for all participating pediatric nursing facilities as determined from their 1991 cost report. This weighted average amount is two hundred twenty dollars and ninety-nine cents ($220.99).

(F) For a change in ownership, management, control, operation or leasehold interest by any form for any facility certified for participation in the Medicaid program at any time, increased capital costs for the successor owners, management or leaseholder shall not be recognized for purposes of reimbursements.

(G) Medicaid reimbursements shall not be paid for services provided to Medicaid-eligible recipients during any time period in which the facility failed to have a Medicaid participation agreement in effect. A per-diem reimbursement rate may not be established for a facility if a Medicaid participation agreement is not in effect.

(H) Upon execution of a Medicaid participation agreement, a qualified facility not previously certified for participation in the Medicaid program shall be assigned a provider number by the Division of Medical Services. Facilities previously certified shall retain the same provider number regardless of any change in ownership, management, control, operation or leasehold interest in any form.

(I) Regardless of changes of ownership, management, control, operation or leasehold interests by whatever form for any facility certified for participation in the Medicaid program, the Division will issue allowable reimbursements to the facility identified in the current Medicaid participation agreement, and recover from that entity liabilities, sanctions and penalties pertaining to the Medicaid program.

(J) A facility's allowable costs shall be apportioned between Medicaid recipients and other patients so that the share borne by the Medicaid program is based upon services actually provided to Medicaid recipients. A facility's allowable costs allocated to the Medicaid program in no case may include costs incurred in providing services for persons who are not Medicaid eligible.

(K) A facility that also is certified for participation in the Title XVIII (Medicare) program shall meet the requirements of Title XVIII of the Social Security Act. Any facility which is terminated from participation in the Medicare program also shall be terminated from participation in the state's Medicaid program.

(L) No restrictions or limitations shall be placed on a recipient's right to select providers of his / her own choice.

(4) Definitions.

(A) Allowable cost. Those costs which are allowable for allocation to the Medicaid program based upon the principles established in this regulation. The allowability of costs not addressed specifically in this regulation shall be determined by the Division of Medical Services. This determination may be based upon criteria such as the Medicare Provider Reimbursement Manual (HIM-15) and section (7) of this regulation.

(B) Average private pay rate. The usual and customary charge for non-Medicaid patients determined by dividing total non-Medicaid days of care into revenue collected from the same service that is included in the Medicaid per-diem rate, excluding negotiated payment methodologies with state or federal agencies, such as the Veterans Administration and the Missouri Department of Mental Health.

(C) Cost report. The Financial and Statistical Report for Nursing Facilities, required attachments as specified in subsection (10)(A) of this regulation and all worksheets supplied by the division for this purpose. The cost report shall detail the cost of rendering both covered and noncovered services for the fiscal reporting period in accordance with the procedures prescribed by the Division.

(D) Department. The Department, unless otherwise specified, refers to the Missouri Department of Social Services.

(E) Desk review. The Division of Medical Services' review of a provider's cost report without on-site audit.

(F) Director. The director, unless otherwise specified, refers to the Director, Missouri Department of Social Services.

(G) The Division of Aging. The division of the Department of Social Services responsible for survey, certification and licensure of LTC facilities.

(H) The Division of Medical Services. Unless otherwise designated, division as used in this regulation refers to the Division of Medical Services, the division of the Department of Social Services charged with administration of Missouri's Medical Assistance (Medicaid) program.

(I) The Dodge Calculator (formerly known as the Dodge Construction Index). The cost per square foot as published in Calculator for a convalescent/nursing home of good quality, masonry wall construction as of mid-year 1970 and adjusted by the general purpose Local Building Cost Multiplier as of the date the initial Certificate of Need (CON) was issued or, if a six (6)-month extension was granted, as of the date the extension was granted. The Local Building Cost Multipliers used to adjust costs shall be those established for Columbia, Kansas City and St. Louis. The multiplier to be used in determining a facility's rate shall be the one established for the city geographically closest to the facility as determined by the air distance from that city to the facility. If the air distance is not available, the determination shall be based on road miles from that city to the facility as determined by the Automobile Club of Missouri (AAA). Calculator is a publication of Calculator, Inc., 12251 Harber Drive, Woodbridge, VA 22192.

(J) Entity. Any natural person, corporation, not-for-profit corporation, professional corporation, business, partnership or something that exists as a particular and distinct unit.

(K) Facility fiscal year. A facility's twelve (12)-month fiscal reporting period covering the same twelve (12)-month period as its federal tax year.

(L) Generally Accepted Accounting Principles (GAAP). Accounting conventions, rules and procedures necessary to describe accepted accounting practice at a particular time promulgated by the authoritative body establishing such principles.

(M) Long-term care (LTC) facility. A licensed skilled nursing facility (SNF), intermediate care facility (ICF), ICF/mentally retarded (MR), SNF/ICF, residential care facility I (RCF I), residential care facility II (RCF II) or other provider of LTC services.

(N) New facility. A newly built facility, for which an approved CON or applicable waiver was obtained and which was newly completed and operational on or after July 1, 1989, and which was originally certified for participation as an SNF.

(O) Occupancy. A facility's total actual patient days divided by the total licensed bed days for the same period.

(P) Patient day. The period of service rendered to a patient between the census-taking hour on two (2) consecutive days. Census shall be taken in all facilities at midnight each day and a census log maintained in each facility for documentation purposes. "Patient day" includes the twelve (12) temporary leave of absence days per any period of six (6) consecutive months for which the Medicaid program

will reimburse the provider. The day of discharge is not a patient day for reimbursement purposes unless it is also the day of admission.

(Q) Pediatric nursing care (facility). Either a new facility with all of the following attributes, or an LTC facility with a valid Medicaid participation agreement in effect on June 30, 1989, with all of the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198, RSMo and must have any other licenses, permits, or both, which may be required by applicable state and local laws;

2. The facility must have one hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid program as an SNF;

3. The facility cannot be either attached to or a distinct part of any other LTC facility or hospital. Distinct part means any portion of any LTC facility or hospital, less than the total beds of the LTC facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(R) Provider. Either a new facility with all of the following attributes, or an LTC facility with a valid Medicaid participation agreement in effect on June 30, 1989, with all of the following attributes on or before June 30, 1990:

1. The facility must be licensed under Chapter 198, RSMo and must have any other licenses, permits, or both, which may be required by applicable state and local laws;

2. The facility must have one hundred percent (100%) of all licensed beds certified by the Division of Aging as meeting the conditions for participation in the Medicaid program as an SNF;

3. The facility cannot be either attached to or a distinct part of any other LTC facility or hospital. Distinct part means any portion of any LTC facility or hospital, less than the total beds of the LTC facility or hospital;

4. The facility must serve only persons under the age of twenty-one (21);

5. The facility must be located in Missouri; and

6. The facility must have a valid participation agreement in effect with the Missouri Division of Medical Services.

(S) Related parties. Parties are related when any one (1) of the following circumstances apply:

1. An entity where, through its activities, one (1) entity's transactions are for the benefit of the other and the benefits exceed those which are usual and customary in those dealings;

2. An entity has an ownership or controlling interest in another entity and the entity, or one (1) or more relatives of the entity, has an ownership or controlling interest in the other entity. For the purposes of this paragraph, ownership or controlling interest does not include a bank, savings bank, trust company, building and loan association, savings and loan association, credit union, industrial loan and thrift company, investment banking firm or insurance company unless the entity directly, or through a subsidiary, operates a facility; or

3. As used in this section, the following terms mean:

A. Indirect ownership/interest means an ownership interest in an entity that has an ownership interest in another entity. This term includes an ownership interest in any entity that has an indirect ownership interest in an entity;

B. Ownership interest means the possession of equity in the capital, in the stock or in the profits of an entity;

C. Ownership or controlling interest is when an entity:

(I) Has an ownership interest totalling five percent (5%) or more in an entity;

(II) Has an indirect ownership interest equal to five percent (5%) or more in an entity. The amount of indirect ownership interest is determined by multiplying the percentages of ownership in each entity;

(III) Has a combination of direct and indirect ownership interest equal to five percent (5%) or more in an entity;

(IV) Owns an interest of five percent (5%) or more in any mortgage, deed of trust note or other obligation secured by an entity if that interest equals at least five percent (5%) of the value of the property or assets of the entity. The percentage of ownership resulting from these obligations is determined by multiplying the percentage of interest owned in the obligation by the percentage of the entity's assets used to secure the obligation;

(V) Is an officer or director of an entity; or

(VI) Is a partner in an entity that is organized as a partnership; and

D. Relative means person related by blood, adoption or marriage to the fourth degree of consanguinity.

(T) Restricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments which must only be used for a specific purpose designated by the donor.

(U) Second prior year cost report. The cost report for the facility fiscal year which ends in the second calendar year prior to the calendar year in which the state's fiscal year ends. For example, for state Fiscal Year 1990, the second prior year cost report would be the cost report for a facility fiscal year which ends any time in calendar year 1988.

(V) Skilled nursing facility (SNF). An LTC facility licensed and certified by the Division of Aging as meeting the conditions for participation in the Medicaid program as an SNF.

(W) Unrestricted funds. Funds, cash or otherwise, including grants, gifts, taxes and income from endowments, that are given to a provider without restriction by the donor as to their use.

(5) Covered Supplies, Items and Services. All supplies, items and services covered in the per-diem rate must be provided to the resident

as necessary, and the facility may not charge the resident, any entity or any other payer any additional amounts for these items, except that supplies and services which would otherwise be covered in a per-diem rate but which are also billable to the Title XVIII Medicare program must be billed to that program. Covered supplies, items and services include, but are not limited to, the following:

(A) Services, items and supplies which must be provided by SNFs as set forth in Title 42 Code of Federal Regulations;

(B) Semiprivate room and board;

(C) Private room and board when it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech and the like;

(D) Temporary leave of absence days, not to exceed twelve (12) days per any period of six (6) consecutive months;

(E) Provision of nursing services;

(F) Provision of personal hygiene and routine care services;

(G) All laundry service, including personal laundry;

(H) All dietary services, including special dietary supplements used for tube feeding or oral feeding. Dietary supplements prescribed by a physician are also covered items;

(I) All consultative services required by federal or state law or regulation;

(J) All therapy services required by federal or state law or regulation;

(K) All routine care items, including disposables and including, but not limited to, those items specified in Appendix A to this regulation;

(L) All nursing care services and supplies, including disposables, and including, but not limited to, those items specified in Appendix A to this regulation; and

(M) Any and all nonlegend antacids, nonlegend laxatives, nonlegend stool softeners and nonlegend vitamins. Providers may not elect which nonlegend drugs in any of the four (4) categories to supply; any and all must be provided to residents as needed and are included in a facility's per-diem rate.

(6) Noncovered Supplies, Items and Services. All supplies, items and services which are not either covered in a facility's per-diem rate, billable to another program in the Missouri Medical Assistance (Medicaid) program, or billable to Medicare or other third-party payors. Noncovered supplies, items and services include, but are not limited to, the following:

(A) Private room and board unless it is necessary to isolate a recipient due to a medical or social condition, examples of which may be contagious infection, loud irrational speech, etc.;

(B) Bed reservations for recipients who are away from the facility for any reason other than a temporary leave of absence day; Temporary leave of absence days in excess of twelve (12) per any period of six (6) consecutive months are noncovered;

(C) Supplies, items and services for which payment is made under Missouri Medical Assistance (Medicaid) program directly to a provider or providers other than providers of the pediatric nursing care services, including, but not limited to, those set forth in Appendix B to this regulation; and

(D) Supplies, items and services provided nonroutinely to residents for personal comfort or convenience, including, but not limited to, those set forth in Appendix B to this regulation.

(7) Allowable Cost Areas.

(A) Compensation of Owners.

1. Compensation of services of owners shall be an allowable cost area, provided the services are actually performed, are necessary and are reasonable.

2. Compensation shall mean the total benefit, within the limitations set forth in this rule, received by the owner for the services s/he renders to the facility, including direct payments for managerial, administrative, professional and other services, amounts paid for the personal benefit of the owner, the cost of assets and

services which the owner receives from the provider and additional amounts determined to be the reasonable value of the services rendered by sole proprietors or partners and not paid by any method previously described in this rule. Compensation must be paid (whether in cash, negotiable instrument or in kind) within seventy-five (75) days after the close of the period in accordance with the guidelines published in the Medicare Provider Reimbursement Manual (PRM), Part 1, Section 906.4.

3. Reasonableness of compensation shall be limited as prescribed in subsection (8)(T).

4. Necessary services refers to those services that are pertinent to the operation and sound conduct of the facility; had the owner not rendered these services, then employment of another entity to perform the service would be necessary.

(B) Covered services and supplies as defined in section (5) of this Plan.

(C) Real Estate and Personal Property Taxes. Taxes levied on or incurred by a facility.

(D) Value of Services of Employees. Except as provided for in this rule, the value of services performed by employees or contractors in the facility shall be included as an allowable cost area to the extent actually compensated, either to the employee or to the contractor.

B. Amounts paid by tax-exempt organizations to purchase tax-sheltered annuities for employees shall be treated as deferred compensation actually paid by the provider.

C. Amounts funded to deferred compensation plans together with associated income shall be recaptured, if not actually paid when due, as an offset to expenses on the cost report form.

(F) Education and Training Expenses.

1. The cost of on-the-job training which directly benefits the quality of health care or administration at the facility shall be allowable. Off-the-job training involving extended periods exceeding five (5) continuous days is an allowable cost item only when specifically authorized in advance in writing by the division.

2. Costs of education and training shall include incidental travel costs but will not include leaves of absence or sabbaticals.

(G) Advertising Costs. Advertising costs which are reasonable and appropriate.

(H) Cost of Supplies Involving Related Parties. Costs of goods and services furnished by related parties shall not exceed the lower of the cost to the supplier or the prices of comparable goods or services obtained elsewhere. In the uniform cost report, a provider shall identify related-party suppliers and the type, quantity and costs of goods and services obtained from each supplier.

(I) Utilization Review. Costs incurred for the performance of required utilization review.

(J) Nursing Facility Reimbursement Allowance (NFRA). Effective for service dates on or after October 1, 1996, the fee assessed to nursing facilities in the State of Missouri for the privilege of doing business in the state will be an allowable cost.

(8) Nonallowable Costs. Cost not reasonably related to pediatric nursing care facility services shall not be included in a provider's costs. In accordance with this section, contractual allowances, courtesy discounts, charity allowances and similar adjustments or allowances are offsets to revenue and are not included in allowable costs. Nonallowable cost areas include, but are not limited to, the following:

(A) Amortization on intangible assets;

(B) Attorney fees related to litigation;

(C) Bad debts;

(D) Capital cost increases due solely to changes in ownership, management, control, operation or leasehold interest;

(E) Central office or pooled costs not reasonably attributed to the efficient and economical operation of the facility;

(F) Charitable contributions;

(G) Compensation paid to a relative or an owner through a related party to the extent it exceeds the limitations established under subsection (7)(A) of this regulation;

(H) Cost arising from joint use of resources (including central office and pooled cost) not directly related to patient care;

(I) Cost not directly related to the provision of patient care;

(J) Cost of ancillary services covered by Medicare Part B;

(K) Cost (for example, legal fees, accounting and administration costs, travel costs and the costs of feasibility studies) which is attributable to the negotiation or settlement of the sale or purchase of any capital asset by acquisition or merger for which any payment has been previously made under the program;

(L) Directors' fees from any source;

(M) Federal, state or local income and excess profit taxes, including any interest and penalties paid on them;

(N) Finders' fees;

(O) Franchise taxes;

(P) Fund-raising expenses;

(Q) Interest expense on intangible assets;

(R) Life insurance premiums for officers and owners and related parties except the amount relating to a bona fide nondiscriminatory employee benefits plan;

(S) Noncovered supplies, services and items as defined in section (6);

(T) Owners' compensation in excess of the high range of the most recent survey of administrative salaries paid to individuals other than owners for proprietary and nonproprietary providers as published in the updated Medicare Provider Reimbursement Manual (PRM) Part 1, Section 905.2.;

(U) Prescription drugs;

(V) Religious items or supplies or services of a primarily religious nature performed by priests, rabbis, ministers or other similar types of professionals. Cost associated with portions of the physical plant used primarily for religious functions are also nonallowable;

(W) Research costs;

(X) Resident personal purchases;

(Y) Return on equity;

(Z) Salaries, wages or fees paid to nonworking officers, employees or consultants;

(AA) Self-employment taxes;

(BB) Stockholder relations or stock proxy expenses;

(CC) Taxes or assessments for which exemptions are available;

(DD) Value of services (imputed or actual) rendered by nonpaid workers or volunteers; and

(EE) Vending machines and related supplies.

(9) Revenue Offsets.

(A) Other revenues must be identified separately in the cost report if included in gross revenues. These revenues include, but are not limited to, the following:

1. Income from telephone services;

2. Sale of employee and guest meals;

3. Sale of medical abstracts;

4. Sale of scrap and waste food or materials;

5. Rental income;

6. Cash, trade, quantity, time and other discounts;

7. Purchase rebates and refunds;

8. Recovery on insured loss;

9. Parking lot revenues;

10. Vending machine commissions or profits;

11. Sales from drugs to individuals other than Medicaid recipients;

12. Interest income to the extent of interest expense;

13. Any income from investments;

14. Room reservation charges in excess of covered therapeutic home leave days;

15. Private room differential; and

16. Reimbursement for nurse-aid training which is not provided as part of the per-diem rate.

(B) Interest income received from a funded depreciation account will not be deducted from allowable operating costs if the interest is applied to the asset being depreciated.

(C) Restricted funds designated by the donor prior to the donation for payment of operating costs will be offset from the associated cost.

(D) Restricted funds designated by the donor for future capital expenditures will not be offset from allowable expenses at any time.

(E) Unrestricted funds not designated by the provider for future capital expenditures will be offset from allowable cost.

(F) Unrestricted funds received from endowments will not be offset from allowable cost.

(G) As applicable, restricted and unrestricted funds will be offset in each cost category, except capital, in an amount equal to each category's proportionate share of allowable expense. The applicable categories are patient care costs and general and administrative costs as defined in section (11).

(H) Any tax levies which are collected by nursing home districts or county homes that are supported in whole or in part by these levies will not be recognized as a revenue offset except to the extent that the funds are used for the actual operation of the facility.

(10) Provider Reporting and Recordkeeping Requirements.

(A) Annual Cost Report.

1. Each provider shall adopt the same twelve (12)-month fiscal period for completing its cost report as is used for federal income tax reporting.

2. Each provider is required to complete and submit to the Division of Medical Services an annual cost report, Financial and Statistical Report for Nursing Facilities, including all worksheets, attachments, schedules and requests for additional information from the division. The cost report shall be submitted on forms provided by the division for that purpose.

3. All cost reports shall be completed in accordance with the requirements of this rule and the cost report instructions. Financial reporting shall adhere to GAAP except as otherwise specifically indicated in this regulation.

4. The cost report submitted must be based on the accrual basis of accounting. Governmental institutions operating on a cash or modified-cash basis of accounting may continue to report on that basis, provided appropriate treatment under GAAP of capital expenditures is made.

5. Cost reports shall be submitted by the first day of the sixth month following the close of the fiscal period.

6. If a cost report is more than ten (10) days past due, payment will be withheld from the facility until the cost report is submitted. Upon receipt of a cost report prepared in accordance with this rule, the payments that were withheld will be released to the provider. For cost reports which are more than ninety (90) days past due, the department may terminate the provider's Medicaid participation and retain all payments which have been withheld pursuant to this provision.

7. Authenticated copies of signed agreements and other significant documents related to the provider's operation and provision of care to Medicaid recipients must be attached to the cost report at the time of filing unless current and accurate copies have already been filed with the division. Material which must be submitted includes, but is not limited to, the following:

A. Audit, review or compilation statement prepared by an independent accountant, including disclosure statements and management letter or SEC Form 10-K;

B. Contracts or agreements involving the purchase of facilities or equipment during the last seven (7) years;

C. Contracts or agreements with owners or related parties;

D. Contracts with consultants;

E. Documentation of expenditures, by line item, made under all restricted and unrestricted grants;

F. Federal and state income tax returns for the fiscal year, within ten (10) days of filing the returns;

G. Leases, rental agreements, or both, related to the activities of the provider;

H. Management contracts;

I. Medicare cost report;

J. Statement verifying the restriction as specified by the donor, prior to donation, for all restricted grants; and

K. Working trial balance actually used to prepare cost report with line number tracing notations or similar identifications.

8. Cost reports must be fully, clearly and accurately completed, all required attachments must be submitted and any requests for additional information or clarification must be provided before a cost report is considered complete. If any additional information, documentation or clarification requested by the division or its authorized agent is not provided within fourteen (14) days of the date of receipt of the request, payments will be withheld from the facility until the information is submitted. If information requested is not received by June 1 prior to the rate determination date, rate increases based upon the cost report will not be effective until sixty (60) days after receipt of requested information, and rate decreases based upon the cost report will be retroactive to the July 1 rate determination date.

9. The division will not accept amended cost reports for rate determination unless they are received by March 31 prior to the rate determination date. Under no circumstances will the division accept amended cost reports for rate redetermination after the rate has been established.

(B) Certification of Cost Reports.

1. The accuracy and validity of the cost report must be certified by the provider. Certification must be made by one (1) of the following persons authorized by the governing body of the provider

to make such certification: for an incorporated entity, an officer of the corporation; for a partnership, a partner; for a sole proprietorship or sole owner, the owner or licensed operator; or for a public facility, the chief administrative officer of the facility. Proof of the authorization shall be furnished upon request.

2. Cost reports must be notarized by a licensed notary public.

3. The following statement must be signed on each cost report to certify its accuracy and validity:

Certification Statement: Misrepresentation or falsification of any information contained in this cost report may be punishable by fine, imprisonment, or both, under state or federal law.

I hereby certify that I have read the above statement and that I have examined the accompanying cost report and supporting schedules prepared by _____ (Provider name and number) for the cost report period beginning _____,19 ____ and ending _____, 19 _____, and that to the best of my knowledge and belief, it is a true, correct and complete statement prepared from the books and records of the provider in accordance with applicable instructions, except as noted.

_____	_____	_____
(Signature)	(Title)	(Date)

(C) Adequate Records and Documentation.

1. A provider must keep records in accordance with GAAP and maintain sufficient internal control and documentation to satisfy audit requirements and other requirements of this rule, including reasonable requests by the Division or its authorized agent for additional information.

2. Each of a provider's funded accounts must be maintained separately with all account activity clearly identified.

3. Adequate documentation for all line items on the cost report shall be maintained by a provider. Upon request, all original documentation and records must be made available for review by the division or its authorized agent at the same site at which the services were provided. Copies of documentation and records shall be submitted to the Division or its authorized agent upon request.

4. A provider must retain all records and documentation for seven (7) years from the cost report filing date. All current providers, regardless of length of participation in the Medicaid program, are responsible for providing access to the facility's records and documentation for seven (7) years.

(D) Audits.

1. Any cost report submitted may be subject to field audit by the Division or its authorized agent.